

AMENDED IN ASSEMBLY JUNE 30, 2003

AMENDED IN SENATE JUNE 3, 2003

AMENDED IN SENATE APRIL 29, 2003

AMENDED IN SENATE APRIL 10, 2003

SENATE BILL

No. 130

Introduced by Senator Chesbro

February 5, 2003

An act to add Division 1.5 (commencing with Section 1180) to the Health and Safety Code, relating to mental health.

LEGISLATIVE COUNSEL'S DIGEST

SB 130, as amended, Chesbro. Health and care facilities: use of seclusion and behavioral restraints.

Existing law provides for the licensure and regulation of health facilities, including various types of hospitals that provide mental health treatment services, by the State Department of Health Services.

Existing law, the California Community Care Facilities Act, provides for the licensure and regulation of community care and residential facilities by the State Department of Social Services. Existing law authorizes these facilities to provide mental health treatment services.

Under existing law, the State Department of Mental Health is charged with the state administration of state hospitals for the mentally disordered.

Under existing law, these facilities are authorized to provide secure containment or use seclusion and restraints, as specified, on patients.

This bill would require the California Health and Human Services Agency to ~~develop policies to reduce, and demonstrate leadership in~~

~~reducing, the use of seclusion and behavioral restraints in facilities, as defined, and to provide oversight to accomplish these purposes. This bill would require the secretary of the agency to coordinate efforts to meet the requirements of this bill by involving the State Department of Health Services, the State Department of Mental Health, and the State Department of Social Services, as well as other agencies and stakeholders, as determined by the secretary provide leadership and coordination necessary to reduce the use of seclusion and behavioral restraints in facilities that are licensed, certified, or monitored by departments that fall within its jurisdiction.~~

~~This bill would require the secretary to collect data, as specified, regarding develop technical assistance and training programs to support the efforts of facilities to reduce or eliminate the use of seclusion and behavioral restraints in these facilities, and to develop take steps to ensure a system of data collection.~~

This bill would authorize specified facilities to use seclusion and behavioral restraints for behavioral emergencies only when a ~~patient's~~ *person's* behavior presents an imminent danger of serious harm to the ~~patient~~ *person* or others, would require an initial assessment of each ~~patient~~ *person* upon admission for these purposes, and would prohibit specified facilities from using specified types of seclusion and behavioral restraints. This bill would also require these facilities to conduct reviews, as specified, for each episode of the use of seclusion or behavioral restraint, to conduct debriefings, as specified, and to document the incident. This bill would also require these facilities to report, as specified, each death or serious injury occurring during, or related to, the use of seclusion or behavioral restraints.

~~This bill would provide that it shall not become operative, and that it is for display purposes only.~~

Vote: majority. Appropriation: no. Fiscal committee: ~~no~~—yes. State-mandated local program: no.

The people of the State of California do enact as follows:

1 SECTION 1. ~~(a)~~—The Legislature finds and declares all of the
2 following:

3 ~~(1) According to a Senate Office of Research report in 2002,~~
4 ~~the use of seclusion and behavioral restraints in psychiatric and~~
5 ~~medical facilities is known to be a dangerous practice that can, and~~
6 ~~sometimes does, result in serious injury, trauma, and even death.~~

1 ~~(2) The federally mandated advocacy organization, Protection~~
2 ~~and Advocacy, Inc., reports that 22 people have died and one~~
3 ~~person has become persistently comatose while in seclusion or~~
4 ~~behavioral restraints in California psychiatric facilities since new~~
5 ~~federal regulations went into effect in July 1999.~~

6 ~~(3) Protection and Advocacy, Inc., further reports that patients~~
7 ~~are at risk of positional asphyxiation when they are restrained in~~
8 ~~a face down or “prone” position. This position can cause sudden~~
9 ~~cardiac arrhythmia or decreased oxygen delivery at a time of~~
10 ~~increased oxygen demand.~~

11 ~~(4) The Harvard Center for Risk Analysis estimates that~~
12 ~~between 50 and 150 deaths occur nationally each year due to the~~
13 ~~use of seclusion and behavioral restraints in psychiatric and~~
14 ~~medical facilities.~~

15 ~~(5) The RAND Corporation estimates that over 100,000~~
16 ~~Californians are involuntarily committed to psychiatric facilities~~
17 ~~each year. Along with an unknown number of voluntarily~~
18 ~~committed patients, any one of them is at risk of being placed in~~
19 ~~seclusion and behavioral restraints.~~

20 ~~(6) The United States General Accounting Office cites~~
21 ~~differing statewide standards as contributing to difficulties in~~
22 ~~obtaining accountability for the use of seclusion and behavioral~~
23 ~~restraints. California is among those states that lack statewide~~
24 ~~standards for the use of seclusion and behavioral restraints. State~~
25 ~~rules governing their use are different, depending on the type of~~
26 ~~facility, and are enforced by different state departments.~~

27 ~~(7) California’s system for tracking the use of seclusion and~~
28 ~~behavioral restraints is inadequate. There is no method for tracking~~
29 ~~injuries caused by the use of seclusion and behavioral restraints.~~
30 ~~In addition, during the year 2000, 22 percent of the facilities that~~
31 ~~were required to report data submitted either an incomplete report~~
32 ~~or none at all.~~

33 ~~(8) In 1997, the State of Pennsylvania launched comprehensive~~
34 ~~reforms in policies regarding the use of seclusion and behavioral~~
35 ~~restraints in nine state hospitals. Labeling seclusion and restraints~~
36 ~~as treatment failure, rather than treatment, Pennsylvania reduced~~
37 ~~the use of seclusion and restraints by 74 percent and the duration~~
38 ~~of time patients spent in seclusion and restraints by 96 percent over~~
39 ~~the next three years. The state reallocated existing funds, using no~~
40 ~~new tax dollars, and successfully reduced injuries to staff as well~~

1 as to patients. In October 2000, Pennsylvania's reform project was
2 awarded the Harvard University Innovations in American
3 Government Award.

4 (b) The Legislature further finds and declares all of the
5 following:

6 (1)–

7 (a) The use of seclusion and behavioral restraints is not
8 treatment, and their use does not alleviate human suffering or
9 positively change behavior. In addition, when used, they are
10 dangerous and dehumanizing to mental health inpatients.

11 (2)–

12 (b) Inactivity, boredom, and confinement in noisy and crowded
13 wards are significant contributors to frustration, conflict, and
14 stress in psychiatric facilities, and lead to the problem of the use
15 of seclusion and behavioral restraints.

16 (3)–

17 (c) An ongoing commitment to varied, active, and stimulating
18 choices of programming is important in addressing the problems
19 of the use of seclusion and behavioral restraints in psychiatric
20 facilities.

21 (4)–

22 (d) The commitment of managers and staff of psychiatric
23 facilities is essential to changing the culture of those facilities and
24 reducing the use of seclusion and behavioral restraints, and
25 providing a safer and more therapeutic environment for mental
26 health patients and staff in California.

27 (5)–

28 (e) In order to achieve the goal of a reduction in the use of
29 seclusion and behavioral restraints, California must utilize the best
30 practices developed in other states, especially Pennsylvania, and
31 use the most efficient modern resources to accomplish these goals,
32 including computerized data collection and analysis, public access
33 to this information on the Internet, strategies for organizational
34 change, staff training in risk assessment, crisis prevention and
35 intervention, patient debriefing models, and recovery-based
36 treatment models.

37 (e)–

38 (f) Adequate numbers of staff are essential to reducing
39 seclusion and behavioral restraints in facilities; however,
40 California faces a human resource crisis in mental health care.

1 According to the California Mental Health Planning Council,
2 vacancy rates for mental health positions in California exceed 30
3 percent. The Employment Development Department estimates that
4 between 1998 and 2008, public and private providers will need to
5 fill 45,000 mental health positions. To address this crisis, the Little
6 Hoover Commission has called for coordinated, integrated, and
7 success-oriented strategies such as hiring clients, recruitment
8 efforts, training academies, scholarships and loan forgiveness,
9 workload analysis, and ensuring training in core competencies.
10 The Legislature finds that resolving California's mental health
11 workforce crisis is important to the goal of reducing seclusion and
12 behavioral restraints in California facilities.

13 (g) It is the intent of the Legislature in enacting this act to
14 ~~require~~ achieve a reduction in the use of seclusion and behavioral
15 restraints ~~in facilities~~ in facilities in California.

16 SEC. 2. Division 1.5 (commencing with Section 1180) is
17 added to the Health and Safety Code, to read:

18
19 DIVISION 1.5. USE OF SECLUSION AND BEHAVIORAL
20 RESTRAINTS IN FACILITIES
21

22 1180. (a) The California Health and Human Services Agency
23 ~~shall, as the lead agency, develop policies to reduce, and shall~~
24 ~~demonstrate leadership in reducing, the use of seclusion and~~
25 ~~behavioral restraints in facilities described in subdivision (b), and~~
26 ~~shall provide oversight, as required, to accomplish the purposes of~~
27 ~~this division.~~

28 ~~(b) The policy changes and oversight described in subdivision~~
29 ~~(a),, in accordance with their mission, shall provide the leadership~~
30 ~~and coordination necessary to reduce the use of seclusion and~~
31 ~~behavioral restraints in facilities that are licensed, certified, or~~
32 ~~monitored by departments that fall within its jurisdiction.~~

33 (b) This division shall apply to all facilities that utilize seclusion
34 or behavioral restraints, including, but not limited to, state
35 hospitals, the psychiatric units of general acute care hospitals,
36 acute psychiatric hospitals, psychiatric health facilities, crisis
37 stabilization units, community treatment facilities, group homes,
38 skilled nursing facilities, *intermediate care facilities, community*
39 *care facilities*, and mental health rehabilitation centers.

(c) For purposes of this division, the following definitions apply:

(1) *“Behavioral restraint” means “mechanical restraint” or “physical restraint” as defined in this section, used as an intervention when a person presents an immediate danger to self or to others. It does not include restraints used for medical purposes, including, but not limited to, securing an intravenous needle or immobilizing a person for a surgical procedure, or postural restraints, or devices used to prevent injury or to improve a person’s mobility and independent functioning rather than to restrict movement.*

(2) *“Containment” means a brief physical restraint of a person for the purpose of effectively gaining quick control of a person who is aggressive or agitated or who is a danger to self or others.*

(3) *“Mechanical restraint” means the use of a mechanical device, material, or equipment attached or adjacent to the patient’s person’s body that he or she cannot easily remove and that restricts the freedom of movement of all or part of a patient’s person’s body or restricts normal access to the patient’s person’s body, and that is used as a behavioral restraint.*

~~(2)~~

(4) *“Physical restraint” means the use of a manual hold to restrict freedom of movement of all or part of a patient’s body, or to restrict normal access to the patient’s body, and that is used as a behavioral restraint. “Physical restraint” also includes is any staff-to-patient physical contact in which the patient unwillingly participates. “Physical restraint” does not include briefly holding a person without undue force in order to calm or comfort, or physical contact intended to gently guide or assist a person from one area to another.*

~~(3) “Containment” means a brief physical holding of a patient for the purpose of effectively gaining quick control of a patient who is aggressive or agitated or who is a danger to self or others.~~

~~(4)~~

(5) *“Seclusion” means the involuntary confinement of a person alone in a room or an area from which the resident is physically prevented from leaving.*

(6) *“Secretary” means the Secretary of the California Health and Human Services Agency.*

~~(d) (1) The secretary shall coordinate efforts to meet the requirements of this division by involving appropriate state departments, including the State Department of Health Services, the State Department of Mental Health, and the State Department of Social Services, as well as other agencies and stakeholders, as determined by the secretary.~~

~~(2) The agencies or entities specified in paragraph (1) shall, upon the request of the secretary, provide information to the~~

~~(7) “Serious injury” means any significant impairment of the physical condition as determined by qualified medical personnel, and includes, but is not limited to, burns, lacerations, bone fractures, substantial hematoma, or injuries to internal organs, whether self-inflicted or inflicted by someone else.~~

~~(d) (1) The agencies or entities specified by the secretary, at the request of the secretary, shall provide information to the secretary regarding their leadership and efforts undertaken to reduce the use of seclusion and behavioral restraints, including, but not limited to, efforts to pursue federal funding for this purpose.~~

~~(3) The secretary shall oversee and coordinate the actions of the departments identified in paragraph (1), and shall collect detailed data on the use of seclusion and behavioral restraints in facilities described in subdivision (b), and on patient injuries or deaths that occur while in seclusion or behavioral restraints. The secretary shall make that information publicly available on the Internet.~~

~~(4)–~~

~~(2) As funds become available, the secretary or his or her designee shall develop technical assistance and training programs to support the efforts of facilities to reduce or eliminate the use of seclusion and behavioral restraints in those facilities that utilize them. Technical assistance and training programs should be designed with the input of clients and direct care staff and should be based on best practices that lead to reduced use of seclusion and behavioral restraints, including, but not limited to, the following:~~

~~(A) Assessment of underlying reasons for the escalated behavior.~~

~~(B) Avoidance and management of crisis situations.~~

~~(C) Treatment planning that identifies risk factors, positive early intervention strategies, and strategies to minimize time spent in seclusion or behavioral restraints.~~

1 (D) Conflict resolution, de-escalation, and client-centered
2 problem solving strategies that diffuse and safely resolve emerging
3 crisis situations.

4 (E) Debriefing strategies that result in client and staff comfort
5 in identifying factors that lead to seclusion or behavioral restraint
6 and factors that would reduce likelihood of future seclusion or
7 behavioral restraint occurrences.

8 (3) The secretary shall pursue federal and private funding to
9 support the development of a training protocol that can be
10 incorporated into the existing training activities for direct care
11 staff conducted by the state, facilities, and educational institutions
12 to reduce the use of seclusion and restraints.

13 ~~(e) The secretary or his or her designee shall develop a system~~
14 ~~of mandatory, consistent, and publicly accessible data collection~~

15 (e) Within existing resources, the secretary or his or her
16 designee shall take steps to ensure a system of mandatory,
17 consistent, timely, and publicly accessible data collection
18 regarding the use of seclusion and behavioral restraints in all
19 facilities described in subdivision (b) that utilize seclusion and
20 behavioral restraints. ~~This data shall be compiled on a basis of~~
21 ~~incidents per 1,000 patient days, in a manner that allows for~~
22 ~~standard statistical comparison. The secretary or his or her~~
23 ~~designee shall create and maintain a list of all facilities subject to~~
24 ~~these requirements. In addition, the secretary shall develop a~~
25 ~~mechanism for making this information publicly available on the~~
26 ~~Internet within 30 days of data collection, and for enforcement of~~
27 ~~these requirements. The secretary shall develop a system of~~
28 ~~penalties payable by any facility that does not meet these~~
29 ~~requirements.~~

30 ~~(f) The secretary or his or her designee shall collect the~~
31 ~~following data on the use of seclusion and behavioral restraints: In~~
32 ~~determining a system of data collection, the secretary should~~
33 ~~utilize existing efforts, and direct new or ongoing efforts, of~~
34 ~~associated state departments to revise or improve their data~~
35 ~~collection systems. The secretary should consider a mechanism to~~
36 ~~ensure compliance by facilities, including, but not limited to,~~
37 ~~penalties for failure to report in a timely manner. It is the intent of~~
38 ~~the Legislature that data be compiled in a manner that allows for~~
39 ~~standard statistical comparison and be maintained for each~~

1 facility subject to reporting requirements for the use of seclusion
2 and behavioral restraints.

3 (f) The secretary shall develop a mechanism for making this
4 information publicly available on the Internet as soon as possible.

5 (g) Data collected pursuant to subdivision (e) shall include all
6 of the following:

7 (1) The number of deaths that occur while a ~~patient~~ person is
8 in seclusion or behavioral restraints, or where it is reasonable to
9 assume that the death was proximately related to the use of
10 seclusion or behavioral restraints.

11 (2) The number of serious injuries sustained by ~~patients~~
12 persons while in seclusion or subject to behavioral restraints. ~~For~~
13 ~~purposes of this division, “serious injury” means any significant~~
14 ~~impairment of the physical condition of a patient as determined by~~
15 ~~qualified medical personnel, and includes, but is not limited to,~~
16 ~~burns, lacerations, bone fractures, substantial hematoma, or~~
17 ~~injuries to internal organs, whether self-inflicted or inflicted by~~
18 ~~someone else.~~

19 (3) The number of ~~staff injuries~~ serious injuries sustained by
20 staff that occur during the use of seclusion or behavioral restraints.

21 (4) The number of incidents of seclusion.

22 (5) The number of incidents of use of behavioral restraints.

23 (6) The duration of time spent *per incident* in seclusion.

24 (7) The duration of time spent *per incident* subject to
25 behavioral restraints.

26 (8) The use of involuntary emergency medication.

27 ~~(9) Patient day information.~~

28 ~~(g) Emergency rooms shall provide the secretary with the data~~
29 ~~required in subdivision (f), except for the patient day information~~
30 ~~specified in paragraph (9) of subdivision (f). In addition, the~~
31 ~~secretary shall formulate a workgroup to study the special issues~~
32 ~~regarding the use of seclusion and behavioral restraints in~~
33 ~~emergency room settings, and to make special recommendations~~
34 ~~in order to reduce the use of seclusion and restraints in those~~
35 ~~settings.~~

36 ~~(h) The secretary shall assess the impact of staff injuries;~~

37 (h) Within existing resources, the secretary shall make
38 recommendations for additional facilities or additional units or
39 departments within facilities that should be included within the

1 *requirements of this section, including, but not limited to,*
2 *emergency rooms.*

3 *(i) Within existing resources, the secretary or his or her*
4 *designee shall assess the impact of serious staff injuries sustained*
5 *during the use of seclusion or behavioral restraints, on staffing*
6 *costs and on workers' compensation claims and costs.*

7 ~~*(i) The secretary or his or her designee shall review and*~~
8 ~~*minimize redundancies in paperwork requirements.*~~

9 *(j) Within existing resources, the secretary or his or her*
10 *designee shall work with the state departments that have*
11 *responsibility for oversight of seclusion and behavioral restraints*
12 *to review and eliminate redundancies and outdated requirements*
13 *in the reporting of data on seclusion and behavioral restraints.*

14 1180.1. A facility described in subdivision (b) of Section 1180
15 shall conduct an initial assessment of each ~~patient~~ *person* upon
16 admission to the facility, or as soon thereafter as possible. This
17 assessment shall include input from the ~~patient~~ *person* and from a
18 family member, significant other, or ~~person~~ *authorized*
19 *representative* designated by the ~~patient~~ *person*, if he or she
20 desires, *and if the desired third party can be present at the time of*
21 *admission.* This assessment shall also include all of the following:

22 (a) A ~~patient's~~ *person's* advance directive regarding
23 deescalation or the use of seclusion or behavioral restraints.

24 (b) Identification of early warning signs, triggers, and
25 precipitants that cause a ~~patient~~ *person* to escalate, and
26 identification of the earliest precipitant of aggression for ~~patients~~
27 *persons* with a known or suspected history of aggressiveness, or
28 ~~patients~~ *persons* who are currently aggressive.

29 (c) Techniques, methods, or tools that would help the ~~patient~~
30 *person* control his or her behavior.

31 (d) Preexisting medical conditions or any physical disabilities
32 or limitations that would place the ~~patient~~ *person* at greater risk
33 during restraint or seclusion.

34 ~~(e) Any history of sexual or physical abuse.~~

35 *(e) Any trauma history, including any history of sexual or*
36 *physical abuse that the affected person feels is relevant.*

37 1180.2. A facility described in subdivision (b) of Section 1180
38 may use seclusion or behavioral restraints ~~on patients~~ for
39 behavioral emergencies only when a ~~patient's~~ *person's* behavior

1 presents an imminent danger of serious harm to ~~the patient~~ *self* or
2 others.

3 1180.3. (a) A facility described in subdivision (b) of Section
4 1180 may not use either of the following ~~on patients~~:

5 (1) A physical restraint or containment technique that obstructs
6 a ~~patient's~~ *person's* respiratory airway or impairs the ~~patient's~~
7 *person's* breathing or respiratory capacity, including techniques in
8 which a staff member places pressure on a ~~patient's~~ *person's* back
9 or places his or her body weight against the ~~patient's~~ *person's* torso
10 or back.

11 (2) A pillow, blanket, or other item ~~under or over the patient's~~
12 *covering the person's* face as part of a physical or mechanical
13 restraint or containment process.

14 (b) A facility described in subdivision (b) of Section 1180 may
15 not use physical or mechanical restraint or containment on a
16 ~~patient~~ *person* who has a known medical or physical condition, and
17 where there is reason to believe that the use would endanger the
18 ~~patient's~~ *person's* life or exacerbate the ~~patient's~~ *person's* medical
19 condition.

20 (c) A facility described in subdivision (b) of Section 1180 may
21 not use prone mechanical restraint on a patient at risk for positional
22 asphyxiation as a result of one of the following ~~known risk factors~~
23 *risk factors that are known to the provider*:

24 (1) Obesity.

25 (2) Pregnancy.

26 (3) Agitated delirium or excited delirium syndromes.

27 (4) Cocaine, methamphetamine, or alcohol intoxication.

28 (5) Exposure to pepper spray.

29 (6) Preexisting heart disease, including, but not limited to, an
30 enlarged heart and other cardiovascular disorders.

31 (7) Respiratory conditions, including emphysema, bronchitis,
32 or asthma.

33 (d) A facility described in subdivision (b) of Section 1180 shall
34 avoid the deliberate use of prone containment techniques
35 whenever possible, *utilizing the best practices in early*
36 *intervention techniques such as deescalation*. If prone
37 containment techniques are used in an emergency situation, a
38 ~~minimum of two staff members shall be involved in the restraint~~
39 ~~application. A third~~ *a staff member shall observe the patient for*
40 any signs of physical duress throughout the use of prone

1 containment. ~~The~~ *Whenever possible, the* staff member
2 monitoring the patient shall not be involved in restraining the
3 patient. ~~The staff member monitoring the patient shall be trained~~
4 ~~in ensuring adequate patient respiration, circulation, and overall~~
5 ~~well-being. A staff member using prone containment on a patient~~
6 ~~shall roll or turn the patient from the prone position as soon as~~
7 ~~possible.~~

8 (e) A facility described in subdivision (b) of Section 1180 may
9 not place a patient in a facedown position with hands held or
10 restrained behind the patient's back.

11 (f) A facility described in subdivision (b) of Section 1180 may
12 not use physical restraint or containment as an extended
13 ~~procedure, and the use of physical restraint or containment may~~
14 ~~not exceed 10 minutes.~~ *procedure.*

15 (g) A facility described in subdivision (b) of Section 1180 shall
16 keep under constant, face-to-face human observation a person who
17 is in seclusion ~~or~~ *and* in any type of behavioral restraint *at the same*
18 *time.*

19 (h) A facility described in subdivision (b) of Section 1180 shall
20 afford to patients who are restrained the least restrictive alternative
21 and the maximum freedom of movement, while ensuring the
22 physical safety of the patient and others, and must use the least
23 number of restraint points.

24 (i) A person in a facility described in subdivision (b) of Section
25 1180 has the right to be free from the use of seclusion and
26 behavioral restraints of any form imposed as a means of coercion,
27 discipline, convenience, or retaliation by staff. This right includes,
28 but is not limited to, the right to be free from the use of a drug used
29 in order to control behavior or to restrict the patient's freedom of
30 movement, if that drug is not a standard treatment for the patient's
31 medical or psychiatric condition.

32 1180.4. (a) A facility described in subdivision (b) of Section
33 1180 shall conduct a clinical, administrative, and quality review
34 for each episode of the use of seclusion or behavioral restraints.

35 (b) A facility described in subdivision (b) of Section 1180 shall,
36 within 24 hours after the use of seclusion or behavioral restraints,
37 conduct a debriefing regarding the incident with the ~~patient, or~~
38 ~~person, and, if the person requests it, the patient's person's family~~
39 ~~member, domestic partner, or advocate if the patient requests~~
40 *significant other or authorized representative*, the staff members

involved in the incident, and a representative of the senior or management staff of the facility, to discuss how to avoid a similar incident in the future. *The person's participation in the debriefing shall be voluntary.* The purposes of the debriefing shall be to do all of the following:

(1) Assist the patient to identify the precipitant of the incident, and suggest methods of more safely and constructively responding to the incident.

(2) Assist the staff to understand the precipitants to the incident, and develop alternative methods of helping the ~~patient~~ *person* avoid or cope with those incidents.

(3) Help treatment team staff devise treatment interventions to address the root cause of the incident and its consequences, and to modify the treatment plan.

(4) Provide an opportunity for both ~~patients~~ *persons* and staff to assess the appropriateness and efficacy of staff response during the emergency, and attend to the ~~patient's~~ *person's* feelings.

(5) Help assess whether the intervention was necessary and whether it was implemented in a manner consistent with staff training and hospital policies.

(c) The facility shall, in the debriefing, provide both the patient and staff the opportunity to discuss the circumstances resulting in the use of seclusion or behavioral restraints, and strategies to be used by the staff, the ~~patient~~ *person*, or others that could prevent the future use of seclusion or behavioral restraints.

(d) The facility staff shall document in the patient's record that the debriefing session took place, ~~and shall include in that documentation the names of staff members who were present for the debriefing, the names of staff who were excused from the debriefing,~~ and any changes to the ~~patient's~~ *person's* treatment plan that resulted from the debriefing.

1180.5. A facility described in subdivision (b) of Section 1180 shall report each death or serious injury occurring during, or related to, the use of seclusion or behavioral restraints. This report shall be made to the agency designated in Section 4900 of the Welfare and Institutions Code no later than the close of the business day following the death or injury. The report shall include the name of the ~~patient~~ *person* involved, and the name, street address, and telephone number of the facility.

1 ~~SEC. 3. Notwithstanding any other provision of this act,~~
2 ~~Section 2 of this act shall not become operative, and is for display~~
3 ~~purposes only.~~

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